ST JOHN OF GOD
Raphael Services

MENTAL HEALTH CARE PLAN

GP Name .....

Address .....

Phone .....

Email .....

Signature ..... Date .....

Use BLOCK LETTERS

Instructions: Complete in addition to Raphael Services Referral Form

Client Name: _____ Date of Birth: ☐☐ ☐☐ ☐☐☐☐ Age: ☐☐

Address: _____ Email: _____

Phone: Home ☐☐ ☐☐☐☐ ☐☐☐☐ Mobile ☐☐ ☐☐☐☐ ☐☐☐☐

Any other relevant information:

Known Allergies:

Outcome Tool Used:	**Results:**

Patient Plan

Patient Needs / Main Issues	**Goals** Record the mental health goals agreed to by the patient and GP and any actions the patient will need to take	**Treatments** Treatments, actions and support services to achieve patient goals	**Referrals** Note: Referrals to be provided by GP, as required, in up to two group of six sessions. The need for the second group of sessions to be reviewed after the initial six sessions
			Referral to Raphael Services for up to 6 sessions
Crisis / Relapse If required, note the arrangements for crisis intervention and/or relapse preventions			

Date Plan Completed:	**Review Date:** (Initial review 4 weeks to 6 months after the completion of plan)

Review Comments (Progress on actions and tasks) Note: If required a separate form may be used for the review.	**Outcome tool results on review**

NO WRITING IN MARGINS

MENTAL HEALTH CARE PLAN

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